

SMALL GROUP PLAN

Employee Enrollment/Change Form

Enrollment

You have the right to read the Group Subscriber Contract and *Evidence of Coverage and Disclosure Form (EOC)* before enrolling in Sutter Health Plus. To help you make an informed choice, we make available Summary of Benefits and Coverage (SBC) documents. SBCs summarize important information about our health coverage options in a standardized format so you can easily compare benefits and coverage offered by Sutter Health Plus with those of other carriers. To obtain a copy, contact your employer or call Sutter Health Plus Member Services 1-855-315-5800 (TTY 1-855-830-3500). This enrollment form is part of the Group Subscriber Contract and *EOC*. You are accepting the terms, conditions, and provisions of the Group Subscriber Contract and *EOC*.

Important Note

The Affordable Care Act (ACA) requires Sutter Health Plus to collect the Social Security numbers (SSN) for all enrolled family members. Sutter Health Plus is required to provide IRS Form 1095-B to the IRS with a copy to you. Form 1095-B includes information you will need to report on your income tax return showing that you and your covered family members had qualifying health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. Sutter Health Plus will not use or share your SSN other than as required by law. **Please be sure to include all SSNs where requested.**

Change Request

This form is also used to inform us of changes to existing members, such as a name, an address, telephone number or sub-account change. **This form is not used to notify us of a termination.** All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Sutter Health Plus.

For Sutter Health Plus to process your request, you must sign and return the last page of this form. Missing information may delay processing.

Fax or email your completed form to:

Fax: 1-916-736-5426

Email: shpenrollmentmailbox@sutterhealth.org

You must encrypt or secure any documents sent by email. If you cannot encrypt or secure emails, please fax all documents and keep a copy for your files.

Language Assistance

If you have questions about completing this application, please contact Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus provides translation services and other language assistance services to you free of charge.

Small Group Employee Enrollment / Change Form

Group Name _____

Effective Date _____

Enrollment – Please complete entire form.

Change – Complete the required information in Sections B and C, if applicable.

Reason For Request:

- Annual Open Enrollment
- Newly Eligible – Reason _____
- New Hire
- COBRA – Effective Date _____
- Cal-COBRA* – Effective Date _____

Member ID (For Changes) _____

- Add Dependent**
- Add Newborn/Newly Adopted Child**
- Remove Dependent – Effective Date _____
- Name Change
- Address Change
- Subaccount
- From Subaccount ID _____ To Subaccount ID _____

*Cal-COBRA enrollees will receive a separate Cal-COBRA Election Notice and Enrollment Form to complete. The notice includes important information regarding health care coverage options and rates.

**Date of qualifying event (if not open enrollment) _____

You need to select a primary care physician (PCP) for yourself and each covered family member. Please include your PCP's name and provider ID in Sections B and C.

Section A – Benefit Plan Selection

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

Platinum	Gold	Silver	Bronze
MS38 HMO	MS37 HMO	MS44 HMO	MS46 HMO
MS50 HMO	MS43 HMO	SD17 HDHP HMO	SD08 HDHP HMO
MS41 HMO	MS42 HMO		

PLUS PLANS

Section A2 – HMO Plus Plan Selection (Plus plans include embedded Infertility and Special Footwear benefits)

Platinum	Gold	Silver	Bronze
MP38 Plus HMO	MP37 Plus HMO	MP44 Plus HMO	MP46 Plus HMO
MP50 Plus HMO	MP43 Plus HMO	SP17 Plus HDHP HMO	SP08 Plus HDHP HMO
MP41 Plus HMO	MP42 Plus HMO		

Optional Adult Vision Benefit

If selected by your employer, you and your dependents age 19 and older will be automatically enrolled in the optional adult vision benefit plan. However, you may opt out of this coverage by checking the box below.

Please do not enroll me or my dependents in the optional adult vision benefit (if selected by my employer). I understand that I will not be able to obtain this coverage until the next applicable open enrollment or special enrollment period.

*Pediatric vision benefits for members age 19 and under (until the end of the month in which the member turns 19 years of age) are included in all Sutter Health Plus small group plans. Please refer to your EOC for coverage information.

Section B – Employee Information

Last Name		First Name		MI
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number (Required)		Subscriber ID Number
Residential Address		City	State	ZIP
Home Phone	Mobile Phone	Work Phone	Email Address	
Mailing Address (P.O. Box Accepted) <input type="checkbox"/> same as residential		City	State	ZIP
Previous Name (If Any)		Primary Spoken Language		

PCP Information – If you do not select a PCP, one will be assigned to you. You have the opportunity to change your PCP by calling Member Services at 1-855-315-5800 (TTY 1-855-830-3500) or on the Member Portal. To find a PCP please visit sutterhealthplus.org/providersearch.

I would like to select my PCP I would like a PCP assigned

PCP Name Provider ID# P **Current Patient?** Yes No

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

Add: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
	First Name	MI	Social Security Number (Required)		
Residential Address		Mailing Address (P.O. Box Accepted) <input type="checkbox"/> same as residential			
City	State	ZIP	City	State	ZIP

I would like to select my PCP I would like a PCP assigned

PCP Name Provider ID# P **Current Patient?** Yes No

Section C2 – Dependent One

Add: <input type="checkbox"/> Child 1	Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
	First Name	MI	Social Security Number (Required)		
Residential Address		Mailing Address (P.O. Box Accepted) <input type="checkbox"/> same as residential			
City	State	ZIP	City	State	ZIP

I would like to select my PCP I would like a PCP assigned

PCP Name Provider ID# P **Current Patient?** Yes No

Section C – Dependent Information Cont.

Section C3 – Dependent Two

Add: Child 2

Last Name _____ **Date of Birth** _____ **Gender** M F

First Name _____ **MI** _____ **Social Security Number (Required)** _____

Residential Address _____ **Mailing Address (P.O. Box Accepted)** same as residential

City _____ **State** _____ **ZIP** _____ **City** _____ **State** _____ **ZIP** _____

I would like to select my PCP I would like a PCP assigned

PCP Name _____ **Provider ID# P** _____ **Current Patient?** Yes No

Section C4 – Dependent Three (If you need additional room, please attach information to the back of this form).

Add: Child 3

Last Name _____ **Date of Birth** _____ **Gender** M F

First Name _____ **MI** _____ **Social Security Number (Required)** _____

Residential Address _____ **Mailing Address (P.O. Box Accepted)** same as residential

City _____ **State** _____ **ZIP** _____ **City** _____ **State** _____ **ZIP** _____

I would like to select my PCP I would like a PCP assigned

PCP Name _____ **Provider ID# P** _____ **Current Patient?** Yes No

Section D – Other Coverage Information

Do you or any of your dependents covered under Sutter Health Plus have any other health plan coverage (in addition to Sutter Health Plus)?

Yes No (If "Yes," please complete all of the information below.)

Primary Policy Holder Name(s) (Last, First, MI) _____ **Policy Number** _____ **Effective Date** _____

Insurance Carrier Name _____ **Policy Holder Date of Birth** _____

All Dependents' Names and Other Health Plan ID Numbers

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plus handles and resolves member disputes through grievance, appeal and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

Employee Signature

Date

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可
能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，
電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صتّر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صتّر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرئي [TTY] 1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա: Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

**សារ:សំខាន់៖ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាន
នរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំ
រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ
1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)**

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができますか？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話：1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉੱਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)